INDEPENDENT AUDITOR'S REPORT

INSPECTOR GENERAL'S REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 2000

To: The Secretary of Health
and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) as of September 30, 2000; the related consolidated statements of net cost and changes in net position; and the combined statements of budgetary resources and financing (principal financial statements) for the fiscal year (FY) then ended. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on them based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the principal financial statements referred to above present fairly, in all material respects, the HHS assets, liabilities, and net position at September 30, 2000; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of forming an opinion on the principal financial statements referred to in the first paragraph. The information in the Overview and the Supplementary Information are not required parts of the principal financial statements but are considered supplemental information required by OMB Bulletin 97-01, *Form and Content of Agency Financial Statements,* as amended. Such information, including trust fund projections,

has not been subjected to the auditing procedures applied in the audit of the principal financial statements. Accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated February 26, 2001, on our consideration of HHS internal controls over financial reporting and on our tests of HHS compliance with certain provisions of laws and regulations. These reports are an integral part of our audit; they should be read in conjunction with this report in considering the results of our audit.

February 26, 2001

REPORT ON INTERNAL CONTROLS

We have audited the principal financial statements of HHS as of and for the year ended September 30, 2000, and have issued our report thereon dated February 26, 2001. We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 01-02, *Audit Requirements for Federal Financial Statements.*

In planning and performing our audit, we considered the HHS internal controls over financial reporting by obtaining an understanding of the HHS internal controls, determining whether internal controls had been placed in operation, assessing control risk, and performing tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 01-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal controls. Consequently, we do not provide an opinion on internal controls.

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the HHS ability to record, process, summarize, and report financial data consistent with management assertions in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts material to the financial statements may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. However, we noted certain matters discussed below involving internal controls and their operation that we consider to be reportable conditions and material weaknesses.

In addition, we considered the HHS internal controls over Required Supplementary Stewardship Information by obtaining an understanding of the HHS internal controls, determining whether these controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin 01-02. Our procedures were not intended to provide assurance on these controls; accordingly, we do not provide an opinion on them.

Finally, with respect to internal controls related to performance measures reported in the *FY 2000 HHS Accountability Report*, we obtained an understanding of the design of significant internal controls related to existence and completeness assertions, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal controls over performance measures; accordingly, we do not provide an opinion on such controls.

Using the criteria and standards established by the American Institute of Certified Public Accountants and OMB Bulletin 01-02, we identified two internal control weaknesses that we consider to be material and two reportable conditions, as follows:

INTERNAL CONTROL WEAKNESSES*

		Page
	Material Weaknesses	
1.	Financial Systems and Processes	4
2.	Medicare Electronic Data Processing	13
	Reportable Conditions	
1.	Medicaid Estimated Improper Payments	17
2.	Departmental Electronic Data Processing	18

* "Financial Systems and Processes," called "Financial Systems and Reporting" in our FY 1999 report, has been retitled to incorporate continued problems with Medicare accounts receivable and Health Care Financing Administration oversight of Medicare contractors. The reportable condition for "Property, Plant, and Equipment" has been removed.

MATERIAL WEAKNESSES

1. Financial Systems and Processes (Repeat Condition)

Since passage of the Chief Financial Officers (CFO) Act, as amended by the Government Management Reform Act of 1994, agencies have prepared financial statements for audit by the Inspectors General. The act emphasized production of reliable financial statements; consequently, HHS worked diligently to prepare statements capable of receiving an unqualified audit opinion. With this year's audit, HHS sustained the important achievement of an unqualified, or "clean," opinion, which we issued for the first time on the FY 1999 financial statements.

A clean audit opinion, however, assures only that the financial statements are reliable and fairly presented. The opinion provides no assurance on the effectiveness and efficiency of agency financial controls and systems, criteria for which may be found in OMB Circular A-123, *Management Accountability and Control*, and OMB Circular A-127, *Financial Management Systems*. Taken together, the criteria require agencies to record, classify, and report on the results of transactions accurately and promptly. Although manual processes may be used, the system(s) must be efficient and effective to accomplish the agency mission and to satisfy financial management needs.

In our view, the Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. Because many systems were not fully integrated and, in some cases, were in the process of being updated or replaced, the preparation of financial statements required numerous manual account adjustments involving billions of dollars. In addition, significant analysis by Department staff, as well as outside consultants, was necessary to determine proper balances months after the close of the fiscal year. Had the operating divisions followed departmental policies and conducted financial analyses and reconciliations throughout the year, many account anomalies would have been detected earlier. While we observed steady improvement in the financial statement process, system and process weaknesses still did not ensure the production of timely and reliable financial statements. These weaknesses related to grant and other accounting issues, Medicare accounts receivable, and Health Care Financing Administration (HCFA) oversight of Medicare contractors.

Background

In addition to the individual operating divisions, two divisions of the Program Support Center play important roles in the departmental financial process: the Division of Financial Operations (DFO) and the Division of Payment Management (DPM).

The DFO provides financial management and accounting services to the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Indian Health Service, the Administration on Aging, the Program Support Center, the Agency for Healthcare Research and Quality, and the Office of the Secretary. The remaining operating divisions — HCFA, the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA) — are responsible for their own accounting.

The DPM provides centralized electronic funding and cash management services for approximately 65 percent of Federal civilian grants and certain contracts. In FY 2000, the DPM Payment Management System made almost 274,000 payments totaling approximately

$195 billion to more than 24,000 grantees on behalf of HHS as well as 10 other Federal agencies and 42 subagencies.

After awarding grants, agencies transmit award amounts and grant payment limits to DPM. Based on these parameters, grantees withdraw funds to pay the expenses of their operations, and they report their expenses to DPM quarterly. The DPM records the withdrawals and expenses and issues reports on these transactions to granting agencies and the Department of the Treasury.

Grant Accounting Issues

From 1970 until July 2000, grant transactions were processed by the DPM Payment Management System on a mainframe computer at the NIH Center for Information Technology. In FY 1994, it was determined that expanding this legacy system was not practical and that the system should be replaced with a new client server, web-enabled system. Programming of the new system began in early FY 1998. In February 1999, a decision was made to defer implementation of the new system until after January 2000, and efforts were then focused on remediating the legacy system for Y2K compliance. Independent public accountants (IPAs) determined that for the period September 1, 1999, through July 28, 2000, the legacy system's internal controls were operating effectively. In July 2000, after successfully running parallel for about a month to test the more critical functions, such as fund transfers, the new Payment Management System was brought online without major incident. Grant authorizations, payment requests, and fund transfers were processed through the system at expected volumes.

However, the expenditure subsystem used to produce and process forms 272, Federal Cash Transactions Report, was not fully tested. The DPM determined that this subsystem could be tested after the new system was implemented and before recipients began returning their completed June 30 (third quarter) expenditure reports in September. While processing the June 30 expenditure reports, two programming problems surfaced. As a result, incomplete or erroneous data were reported to the operating divisions and other customer agencies. First, the algorithm used to allocate expenditures to a common accounting number (CAN) did not function properly. While total expenditures were captured, the amounts were incorrectly distributed to the CANs. Although we noted certain concerns with the allocation of disbursements among the operating divisions, we determined that total cash disbursements charged to the operating divisions, in the aggregate, equaled net cash disbursements reported to the Department of the Treasury and distributed to grant recipients. Second, the new system could not process paper 272 reports; this produced a backlog of about $2.1 billion in unprocessed reports. Compounding these problems, the lead programmer working on the expenditure process unexpectedly left the employment of the system development contractor in August.

After correcting the programming problems, DPM began processing the backlog of expenditure reports. In late September, an expenditure file was distributed to the operating divisions reflecting

what DPM thought was the majority of grantee expenditure reports. **Because DPM was of the opinion that any remaining expenditure amounts would be immaterial, it did not notify any of its customers of this problem.** These assumptions were incorrect. In actuality, many of the paper 272 reports involved large grantees and totaled about $2.1 billion in unprocessed third quarter expenditures. The DPM should have analyzed the unprocessed reports and determined the extent and seriousness of the problem rather than speculate that it was immaterial. These problems were not fully communicated to senior operating division management or the auditors until February 2001. As a result, grant expenditures, grant advances, and the grant accrued expense calculation contained billions of dollars in errors until final correction. The errors caused account anomalies noted by auditors and substantially delayed final conclusion of the audits of NIH, ACF, HRSA, SAMHSA, and CDC and the Department's compilation of the financial statements:

- The DFO, the operating divisions, and/or auditors analyzed grant expenditures reported on the Statement of Net Cost and found that the yearend balances contained aggregate errors of $2.7 billion. This amount included understatements of $2.1 billion ($1 billion for ACF, $1 billion for NIH, and $100 million for CDC) and overstatements of $628 million ($420 million for HRSA, $97 million for CDC, $91 million for SAMHSA, and $20 million for ACF). As a result of these errors, the financial statements initially were materially misstated. Certain operating divisions did not detect these errors through their internal controls.

- The DFO extensively analyzed July and August grant advance transactions reported by DPM and determined that advances recorded in the general ledger were understated by $858 million: $449 million for ACF, $335 million for HRSA, and $74 million for SAMHSA.

- From October 1, 1999, to June 30, 2000, many accounts in the subsidiary detail were not properly classified as intragovernmental or nongovernmental transactions. The absolute value of classification errors in the subsidiary detail was approximately $6.4 billion: $5.4 billion for ACF, $552 million for HRSA, and $445 million for SAMHSA. The DFO ultimately corrected these errors ("outside the general ledger") in its manual yearend process of preparing financial statements.

- The ACF grant transactions of approximately $1.1 billion were recorded to the wrong CAN. As a result, these amounts were reported in the wrong appropriation. We were informed that this occurred because of discrepancies in the CAN table that were not identified until several months after the end of the fiscal year.

Although these four problems were eventually corrected, we remain concerned that the operating divisions did not routinely analyze accounts to detect such accounting anomalies. When such analyses are not performed in the normal business cycle, material errors and irregularities will not be promptly detected and the resulting financial statements will be at risk of inaccuracies. Also, procedures should be established to ensure that detected anomalies are effectively communicated to top management.

Medicare Accounts Receivable

The HCFA is the Department's largest operating division with about $316 billion in net outlays. Along with its Medicare contractors, HCFA is responsible for managing and collecting many billions of dollars of accounts receivable each year. Medicare accounts receivable are primarily overpayments owed by health care providers to HCFA and funds due from other entities when Medicare is the secondary payer. For FY 2000, the contractors reported about $30 billion in Medicare accounts receivable activity which resulted in an ending gross balance of approximately $7.1 billion — over 87 percent of HCFA's total receivable balance. After allowing for doubtful accounts, the net balance was about $3.2 billion.

For several years, we have reported serious errors in contractor reporting of accounts receivable that resulted from weak financial management controls. Control weaknesses were noted again this year. Because the claim processing systems used by the contractors lacked general ledger capabilities, obtaining and analyzing financial data was a labor-intensive exercise requiring significant manual input and reconciliations between various systems and ad hoc spreadsheet applications. The lack of double-entry systems and the use of ad hoc supporting schedules increased the risk that contractors could report inconsistent information or that information reported could be incomplete or erroneous.

To address previously identified problems in documenting and accurately reporting accounts receivable, HCFA began a substantial validation of its receivables by contracting with IPAs in FY 1999. The HCFA continued the validation effort this year. As a result, the receivables balance was adequately supported as of the end of FY 2000.

The IPAs reviewed accounts receivable activity at 14 Medicare contractors which represented over 68 percent of the total Medicare accounts receivable balance at September 30, 1999. While they noted significant improvement in the HCFA central office's analysis of information included in its financial statements, along with improvement in contractors' processing and reporting of receivables, their review identified overstatements and understatements totaling $374 million as of March 31, 2000. This amount included errors of $201 million in Medicare Secondary Payer (MSP) receivables and $173 million in non-MSP receivables. Most of the MSP misstatements were due to a lack of supporting documentation for the amounts reported in the contractors'

quarterly financial reports to HCFA. Misstatements of non-MSP receivables were attributed to the following:

- $74 million resulted from clerical and other errors.
- $50 million should have been eliminated when providers eventually filed their cost reports. Until a provider files a cost report, all outstanding interim payments are considered technical overpayments and are recorded as receivables.
- $47 million was not supported by records.
- $2 million concerned receivables transferred to a HCFA regional office but still included on the contractor's books and thus recorded twice.

While it is quite clear that the root cause of the accounts receivable problem is the lack of an integrated, dual-entry accounting system, HCFA and the Medicare contractors have not provided adequate oversight or implemented compensating internal controls to ensure that receivables will be properly accounted for and reflected in their financial reports. To address its systems problem, HCFA plans to develop a state-of-the-art Integrated General Ledger Accounting System. This system will replace the cumbersome, ad hoc spreadsheets currently used to accumulate and report contractor financial information and will enable HCFA to collect standardized accounting data. In addition, the system will replace HCFA's current accounting system, the Financial Accounting Control System, and will include an accounts receivable module to provide better control and support for receivables. A HCFA-wide project team has been formed under the guidance of the CFO and the Chief Information Officer. Depending on funding, HCFA does not expect to implement the new system until FY 2007.

HCFA Oversight of Medicare Contractors

Pending implementation of a fully integrated accounting system, HCFA's oversight of the Medicare contractors becomes critical to reducing the risk of material misstatement in the financial statements. However, as discussed below, HCFA oversight of contractor operations and financial management controls has not provided reasonable assurance that material errors will be detected in a timely manner.

The responsibility for collecting delinquent provider overpayments is dispersed among the 54 Medicare contractors, the 10 HCFA regional offices, the HCFA central office, and external agencies. The majority of overpayments are recovered by the contractors through offset procedures. However, when the contractors' collection efforts are unsuccessful, delinquent receivables are transferred to the regional offices and then possibly to various other locations,

including the central office, the HCFA Office of General Counsel, the Department of Justice, and the Department of the Treasury's Debt Collection Center.

In an October 28, 1999, report to HCFA (*Safeguarding Medicare Accounts Receivable*, A-17-99-11999), we noted significant weaknesses in regional office accounting for debt. Our review showed that regional and central office accounts receivable were misstated by $184.5 million. Examples of the misstatements included:

- an overstatement of $96.9 million in receivables with no supporting documentation,
- overstatements and understatements totaling $33.9 million due to various reporting and clerical errors, and
- an understatement of $21 million in improperly recorded transfers of receivables from the Medicare contractors to the regional offices.

Not only did the regional offices not safeguard debt in their custody, their monitoring of contractor financial information was inadequate to prevent errors in financial reports and data. As mentioned above, it was necessary for HCFA to hire IPAs to properly determine the accounts receivable balance for the past 2 years. For non-MSP receivables during this period, the IPAs identified about $590 million in recorded debt that the Medicare contractors could not support. While these receivables were written off because of the lack of support, it is possible that some of these receivables were actually debt due to Medicare and should have been collected. Had the regional offices been required to conduct reviews similar to those conducted by the IPAs, many of these problems could have been detected or prevented more timely.

Similarly, stronger regional office oversight of the contractors' reconciliations would help to ensure that contractors have adequate controls in place to prepare accurate and complete financial reports. The HCFA requires all Medicare contractors to reconcile "total funds expended" reported on the prior month's HCFA 1522, Monthly Contractor Financial Report, to adjudicated claims processed using the paid claims tape. This reconciliation is an important control to ensure that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. However, of the 10 contractors in our sample, 9 did not conduct this reconciliation using the actual paid claims tape. Numerous errors and omissions in contractor reporting resulted. For example, at one contractor, over $65 million in paid claims from the current month's HCFA 1522 was inadvertently included in the previous month's HCFA 1522. The contractor's HCFA 1522 had to be resubmitted because an unreported manual payment of $6.3 million had not been posted to the contractor's financial records.

Other Accounting Issues

While the timeliness of the HHS financial statements has improved, delays were noted again this year. Numerous adjusting entries at yearend were needed to correct errors and to develop accurate financial statements. Many of these adjustments would not have been necessary had management routinely reconciled and analyzed accounts throughout the year, recorded transactions using prescribed accounts, and refrained from making "financial statement only" adjustments. These controls help to promptly identify and correct accounting aberrations, provide more reliable financial information during the year, and prevent a material misstatement of the financial statements at yearend. Some examples follow:

National Institutes of Health. The NIH financial system, which dates back to the early 1970s, was not designed for financial reporting purposes and lacks certain system interfaces. Because the accounting function is decentralized among the 25 NIH Institutes and Centers, the NIH Office of Financial Management spent considerable time in consolidating and adjusting 23 trial balances in order to prepare financial statements. The NIH, which had net budget outlays of $15.4 billion, was unable to prepare reliable financial statements for September 30, 2000, until February 2001.

During FY 2000, NIH recorded approximately 9.4 million entries in its financial system. About 18,000 of these entries, with an absolute value of about $200 billion, were recorded using nonstandard accounting entries which could circumvent accounting controls. The bulk of these transactions pertained to FY 1999 manual closing entries. Many of these entries were incorrect and were not corrected until months after the original transactions were recorded. For example, entries totaling $140 million were recorded three times in April 2000. Four months later, the duplicate entries were reversed, leaving the correct entries in the system. In addition, we noted that NIH, as in past years, delayed entering some of the prior year's financial statement adjustments, valued at $5.1 billion, to its general ledger for nearly a full year. Such delays cause the general ledger to be misleading and inaccurate during the year.

For FY 2000, to compensate for system inadequacies, NIH developed an ad hoc, yearend process to create and post correct standard general ledger accounts. The output of this process formed the trial balance. However, an additional 95 entries, totaling an absolute value of approximately $28 billion, were necessary in order to adjust the trial balance to prepare the financial statements.

In 1998, NIH launched a project known as the NIH Business System to replace existing administrative and management systems. Once the new system is fully implemented, we believe that improved financial information will provide for better decision-making, potential cost savings, and a means to meet current Federal accounting and budgetary reporting requirements. However, the system is not expected to be fully operational until 2005.

Administration for Children and Families. The ACF, the second largest operating division with net budget outlays of $37.5 billion, prepared its financial statements more accurately and more timely than last year, largely as a result of having performed many of the required

reconciliations and analyses during the year. But many "Fund Balance with Treasury" reconciliations were performed late, and most of the required budgetary account reconciliations were not performed until yearend to prepare the financial statements.

Fund Balance with Treasury reconciliations deserve particular mention because the differences between the general ledger and the Department of the Treasury's records were so great. At various times, the difference ranged from $200 million to $6.3 billion. This suggests that ACF did not post transactions timely or accurately; in our testing, we found instances of this problem. For example, we noted that a $143 million transaction had been posted to the wrong appropriation and remained uncorrected for over a year.

Recommendations. We recommend that the Assistant Secretary for Management and Budget (ASMB):

- direct each operating division to establish controls to identify and report significant accounting anomalies to top management;
- direct the CFO of the Program Support Center to communicate accounting and control problems more effectively to the CFOs of serviced entities;
- direct that operating division CFOs work with their program office counterparts to develop procedures for analyzing and explaining unusual changes in account balances;
- oversee and maintain close liaison with entities serviced by the Program Support Center and CFO offices during the installation of new systems or the revision of operating procedures;
- continue to support the development of the HCFA Integrated General Ledger Accounting System and oversee its implementation;
- monitor HCFA's corrective actions to strengthen regional office and contractor monitoring of accounts receivable and to ensure that key financial reconciliations are performed timely;
- consider directing operating division CFOs to prepare and analyze interim financial statements, particularly the statements of net cost, budgetary resources, and financing, as an aid in the reconciliation and analysis process; and
- require each operating division to prepare quarterly reports on the status of corrective actions on recommendations in the specific CFO reports on internal

controls. The ASMB, in turn, should summarize and report quarterly on these actions to the Deputy Secretary and OIG.

2. Medicare Electronic Data Processing (Repeat Condition)

The HCFA relies on extensive electronic data processing (EDP) operations at both its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts.

The HCFA central office systems maintain administrative data, such as Medicare enrollment, eligibility, and paid claims data, and process all payments for managed care. In FY 2000, managed care payments totaled about $39.8 billion. The Medicare contractors and data centers use several "shared" systems to process and pay fee-for-service claims. All of the shared systems interface with HCFA's Common Working File (CWF) to obtain authorization to pay claims and to coordinate Medicare Part A and Part B benefits. This network accounted for and processed $173.6 billion in Medicare expenditures during FY 2000.

Our review of EDP internal controls covered general and application controls. General controls involve the entity-wide security program, access controls, application development and program change controls, segregation of duties, operating system software, and service continuity. General controls affect the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of HCFA data. Application controls involve input, processing, and output controls related to specific EDP applications.

We completed general control reviews at nine Medicare data processing facilities that support the Medicare contractors sampled. In addition, we assessed application controls of the Fiscal Intermediary Shared System (FISS), the Multi-Carrier System, and the CWF at three separate contractors. At the HCFA central office, we updated the status of prior-year findings concerning general controls.

We found numerous EDP general control weaknesses, primarily at the Medicare contractors. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in the contractors' entity-wide security structure do not ensure that EDP controls are adequate and operating effectively.

As noted in the following table, a total of 124 weaknesses were identified. The majority were found at the Medicare contractors, and most (about 80 percent) involved three types of controls: access controls, entity-wide security programs, and systems software. While individually the conditions found are not material, the cumulative effect is material.

General Control Audit Areas	Number of Weaknesses		Total
	Central Office	Medicare Contractors	
Access controls	2	55	57
Entity-wide security programs	4	17	21
Systems software	1	20	21
Service continuity/contingency planning	-	11	11
Segregation of duties	1	7	8
Application software development and change controls	1	5	6
Total	**9**	**115**	**124**

Access controls. Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive computer programs and data is granted only when authorized and appropriate. Closely related to these controls are those over computer operating systems and data communications software. These controls further ensure that only authorized staff and computer processes access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. However, access control weaknesses represented the largest problem area. Of the 124 EDP control weaknesses reported, 57, or 46 percent, related to access controls.

- ***Administration of access controls*** (29 conditions: 27 at 11 Medicare contractor sites and 2 at the HCFA central office). In numerous instances, passwords were not properly administered, systems security software was not implemented effectively, or access privileges were not reviewed frequently enough to ensure their continuing validity.

- ***Access to computer programs and system files*** (5 conditions at 5 Medicare contractor sites). At some sites, installation-level controls over critical system software libraries were inadequate, and programmers were inappropriately allowed access to production software program libraries. We also noted cases in which programmers had inappropriate access to system logs; this provided an opportunity to conceal improper actions and obviated the logs' effectiveness as a detect control. At another site, the computer operator could override installation system security precautions when restarting the mainframe computer system.

- ***Access to sensitive data*** (15 conditions at 9 Medicare contractor sites). These are instances in which computer programmers and/or other technical support staff had inappropriate access to the data files used in the claim process. At several sites, programmers had inappropriate access to beneficiary history files. Under these conditions, the CWF system was vulnerable to inappropriate use. At several other sites, programmers had inappropriate access rights to production files, including beneficiary history and other sensitive data. Also, users of one contractor's local area network could access Medicare program data without adequate controls. During vulnerability testing at three Medicare contractor sites, excessive remote access attempts were permitted and more information about the computers being tested was disclosed than necessary. Such weaknesses increase the risk of unauthorized remote access to sensitive Medicare systems.

- ***Physical access*** (8 conditions at 5 Medicare contractor sites). These include weaknesses in controls over access to sensitive facilities and media within those facilities. For example, at one contractor, inappropriate individuals had access to the computer center's command post. At another, the computer production control area was not secured during normal business hours.

Entity-wide security programs. These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are formulated, control techniques are developed, and management oversight is applied to ensure the overall effectiveness of security measures. Programs typically include policies on how and which sensitive duties should be separated to avoid conflicts of interest. Likewise, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems

controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, computer-based operations. Of the 124 EDP control weaknesses reported, 21, or 17 percent, related to security program weaknesses.

- ***Entity-wide plans*** (8 conditions at 8 Medicare contractor sites). Eight contractor sites lacked fully documented, comprehensive entity-wide security plans that addressed all aspects of an adequate security program. One site also had no mechanism for ensuring that system audit findings were effectively addressed and resolved.

- ***Implementation of entity-wide plans*** (13 conditions: 9 at 6 Medicare contractor sites and 4 at the HCFA central office). Inadequate risk assessments, a lack of comprehensive security awareness programs, and inadequate policies were among the weaknesses reported at the contractors. At the HCFA central office, four conditions remained reportable: no security assessment of, or security plans for, significant application systems; deficiencies in the security plan accreditation process; insufficient security oversight of the Medicare contractors; and no formal process to remove system access of terminated HCFA employees and contractors.

Systems software controls. Systems software is a set of programs designed to operate and control the processing activities of computer equipment. Generally, it is used to support and control a variety of applications that may run on the same computer hardware. Systems software helps control and coordinate the input, processing, output, and data storage associated with all of the applications that run on a system. Some systems software can change data and programs on files without leaving an audit trail. Of the 124 EDP control weaknesses, 21, or 17 percent, related to weaknesses in systems software controls (20 at 7 Medicare contractor locations and 1 at the HCFA central office). Problems related to managing routine changes to systems software to ensure their appropriate implementation and configuring controls associated with the operating system to ensure their effectiveness. Such problems could weaken critical controls over access to sensitive Medicare data files and operating system programs.

Shared system weaknesses. We found that the prior control weakness related to the Medicare data centers' having full access to the FISS source code remained unresolved. This weakness has been expanded to include the CWF system, since the design of the CWF software provides for programmer update access to CWF data files to meet operational needs. As we previously reported, Medicare data centers had access to the FISS source code and were able to implement local changes to FISS programs. Such access may be abused, resulting in the implementation and processing of unauthorized programs at contractor data centers. While HCFA requires contractors to restrict local changes to emergency situations, local changes are often not subjected to the same controls that exist in the standard change control process.

HCFA central office. Our followup work found that the HCFA central office had resolved the prior-year deficiency in mainframe database access controls. The central office has also continued to implement enhanced control procedures, specifically in access controls and application development and program change controls. However, actions were still underway as of the end of FY 2000. Improvements not yet completed included:

- issuance of task orders to various contractors to address issues related to risk assessment, security policies and procedures, independent verification and validation of entity-wide security plans, and related procedures for significant systems and

- migration to enterprise-wide program change management software, with full implementation planned during FY 2001.

Recommendation. We recommend that ASMB oversee HCFA's identification and implementation of corrective actions to address the fundamental causes of Medicare EDP control weaknesses. Detailed recommendations are contained in the HCFA audit report.

REPORTABLE CONDITIONS

1. Medicaid Estimated Improper Payments (Repeat Condition)

The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act, is a grant-in-aid medical assistance program largely for the poor, the disabled, and persons with developmental disabilities requiring long-term care. Funded by Federal and State dollars, the program is administered by HCFA in partnership with the States via approved State plans. Under these plans, States reimburse providers for medical assistance to eligible individuals, who numbered more than 33 million in 2000. In FY 2000, Federal and State Medicaid outlays totaled $207.1 billion; Federal expenses were $118.7 billion.

We found that HCFA still lacked a methodology to estimate the extent of improper Medicaid payments on a national level. For the last 5 years, OIG reviewed a statistical sample of Medicare claims and estimated the extent of payments that did not comply with laws and regulations. The majority of errors fell into four broad categories: unsupported services, medically unnecessary services, incorrect coding, and noncovered services. This information helped HCFA to monitor and reduce improper Medicare payments. Because HCFA has not established a similar methodology for the Medicaid program, it cannot reach conclusions on the extent of Medicaid payment errors. We recognize that Medicaid is a State-administered program, so estimates of improper payments will require the cooperation of States.

Our prior report recommended that HCFA work with the States to develop procedures and implement a methodology for determining the extent of improper Medicaid payments. We noted some recent progress in this area. A project coordinator has begun requesting State participation in a pilot error rate project.

Recommendation. We recommend that ASMB and HCFA continue to work with the States to develop procedures and implement a methodology for determining the extent of improper Medicaid payments.

2. Departmental Electronic Data Processing (Repeat Condition)

The following summarizes some of the systemic EDP control weaknesses identified in audits of operating division financial statements and service organization operations. Other weaknesses are reported in the individual reports on these entities. We note that NIH has resolved the previous year's reportable findings related to systems access controls.

Division of Financial Operations. The Program Support Center's DFO uses several automated systems to provide financial services to certain operating divisions. While DFO continues to strengthen controls over these systems, further improvements are needed.

- The DFO entity-wide security program lacked a formal risk assessment, a formal security plan, and adequate personnel security policies. In addition, the security features of the DFO accounting system (CORE) were not accredited as required by OMB Circular A-130. Such weaknesses in the entity-wide security structure limited assurance that EDP controls were adequate and operating effectively.

- The DFO policy for application change control included no formal test procedures and lacked adequate emergency change procedures, as well as adequate library management software. Additionally, DFO did not consistently follow its documented application change control procedures. For example, change request forms, used to ensure that software changes are approved and documented, were not always complete; supervisory approval of program modifications was not consistently documented; and "before and after" images of program code were not compared to ensure that only approved changes were made to the CORE application.

- A penetration test of the DFO internal network and computing resources to assess the security of systems and to identify vulnerabilities determined that user account policies and administrative passwords on servers were weak. This type of weakness increases to a high level the risk that the system will be compromised by unauthorized users.

Food and Drug Administration. In FY 1999, FDA had several findings under each of the six major categories of general controls. Although FDA resolved many of these findings, some were still outstanding this year. When viewed in the aggregate, these exceptions constituted a reportable condition. Areas still in need of improvement included the entity-wide security program, access controls, software application change controls, and service continuity.

Recommendation. We recommend that ASMB oversee the efforts of the operating divisions and service organizations to improve security issues, system access controls, application change controls, and service continuity plans. Specific recommendations are covered in the individual audit reports.

OTHER MATTERS

FMFIA Reporting

As part of our audit, we also obtained an understanding of management's process for evaluating and reporting on internal control and accounting systems, as required by the Federal Managers' Financial Integrity Act (FMFIA), and compared the material weaknesses reported in the HHS FY 2000 FMFIA report relating to the financial statements under audit with the material weaknesses noted in our report on internal controls. Under OMB guidelines for FMFIA reporting, HHS reports as a material weakness any deficiency the Secretary determines to be significant enough to be disclosed outside the agency. This designation requires HHS management to judge the relative risk and significance of deficiencies. In making this judgment, HHS management pays particular attention to the views of the HHS Inspector General. The HHS management agrees with the HHS Inspector General in reporting to the President and the Congress the two material weaknesses described in this report.

Medicare National Error Rate

At HCFA's request, we developed a national error rate of the extent of improper Medicare fee-for-service payments for FY 2000. As discussed in detail in our separate report (CIN: A-17-00-02000), and based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments reported by HCFA. This year's estimate of improper payments is the lowest estimate to date and about half the $23.2 billion that we estimated for FY 1996. There is convincing evidence that this reduction is statistically significant. However, we cannot conclude that this year's estimate is statistically different from the estimates for

FY 1999 ($13.5 billion) or 1998 ($12.6 billion). The decrease this year may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

As in past years, these improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (92 percent) of these improper payments were detected through medical record reviews coordinated by OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although HCFA has made substantial progress since FY 1996 in reducing improper payments in the Medicare program, continued efforts are needed.

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This report is intended solely for the information and use of HHS management, OMB, and the Congress and is not intended to be and should not be used by anyone other than these specified parties.

February 26, 2001

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

We have audited the principal financial statements of HHS as of and for the year ended September 30, 2000, and have issued our report thereon dated February 26, 2001. We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

The HHS management is responsible for complying with applicable laws and regulations. As part of obtaining reasonable assurance about whether the HHS financial statements are free of material misstatement, we performed tests of management compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and with certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996.

The results of our tests of compliance with laws and regulations described in the preceding paragraph, exclusive of FFMIA, disclosed no instances of noncompliance required to be reported under *Government Auditing Standards* or OMB Bulletin 01-02.

Under FFMIA, we are required to report whether HHS financial management systems substantially comply with Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. The results of our tests disclosed instances, described below, in which HHS financial management systems did not substantially comply with Federal financial management system requirements.

- The financial management systems and processes used by HHS and the operating divisions were not adequate to prepare reliable, timely financial statements. Because the Department is decentralized, operating divisions must have efficient and effective systems and processes to report financial results.

  - At HCFA, extensive consultant support was needed to establish reliable accounts receivable balances and to oversee Medicare contractors.

  - The Payment Management System, an application for processing grant payments, did not record and report grant transactions properly.

- C At most operating divisions, suitable systems were not in place to adequately explain significant fluctuations in grant transactions.

- C At NIH, an integrated accounting system was not in place to consolidate the accounting results of transactions by the Institutes. Extensive, time-consuming manual adjustments were needed before reliable financial statements could be prepared.

‘ The EDP internal control weaknesses identified at the sampled Medicare contractors were significant departures from requirements in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

The results of our tests disclosed no instances in which the HHS financial management systems did not substantially comply with applicable Federal accounting standards or the U.S. Government Standard General Ledger.

The HHS CFO prepared a 5-year plan to address FFMIA and other financial management issues. Although certain milestone dates have passed, we recognize that the plan will require periodic updating to reflect changed priorities and available resources.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit; accordingly, we do not express such an opinion.

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This report is intended solely for the information and use of HHS management, OMB, and the Congress. It is not intended to be and should not be used by anyone other than these specified parties.

Michael F. Mangano
Acting Inspector General
Department of Health and Human Services

February 26, 2001
CIN: A-17-00-00014

Appendix I

FISCAL YEAR 2000 CFO REPORTS ON HHS OPERATING DIVISIONS AND SERVICE ORGANIZATIONS

Nine separate financial statement audits of HHS operating divisions were conducted in FY 2000:

- Administration for Children and Families *(CIN: A-17-00-00001)*
- Centers for Disease Control and Prevention *(CIN: A-17-00-00008)*
- Food and Drug Administration *(CIN: A-17-00-00006)*
- Health Care Financing Administration *(CIN: A-17-00-02001)*
- Health Resources and Services Administration *(CIN: A-17-00-00003)*
- Indian Health Service *(CIN: A-17-00-00004)*
- National Institutes of Health *(CIN: A-17-00-00007)*
- Program Support Center *(CIN: A-17-00-00005)*
- Substance Abuse and Mental Health Services Administration *(CIN: A-17-00-00002)*

Four Statement on Auditing Standards 70 examinations were conducted:

- Center for Information Technology, NIH *(CIN: A-17-00-00010)*
- Central Payroll and Personnel System, Program Support Center *(CIN: A-17-00-00012)*
- Division of Financial Operations, Program Support Center *(CIN: A-17-00-00009)*
- Payment Management System, Program Support Center *(CIN: A-17-00-00011*)